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September 5, 2006

FILE COPY

Linda Miller, Administrator
Rosetta Assisted Living - Hiland
1919 Hiland
Burley, ID 83318

Dear Ms. Miller:

On August 21, 2006, a complaint investigation survey was conducted at Rosetta Assisted Living - Hiland. The survey was conducted by Rae Jean McPhillips, R.N. and Karen McDannel, R.N. This report outlines the findings of our investigation.

Complaint # ID00001624

Allegation #1: An identified resident fell out of bed on May 29, 2006. The facility called the husband and told him she had a "rug burn" on her forehead. When the family visited on May 30, 2006, they noticed that she had a large knot on her forehead that was bruised and bloodied. She also had a black eye.

Findings: Based on interview and record review it was determined the identified resident did fall out of bed on May 29, 2006, at 3:30 a.m. and sustained a carpet burn to the left side of her face and forehead.

On August 21, 2006 at 11:45 a.m., the administrator, the regional director, and one staff member were interviewed regarding the identified resident's fall. They stated the resident had a fall out of bed on May 29, 2006, when her feet got tangled in her covers. Staff assisted the resident back to bed after checking her over. They documented the identified resident sustained an abrasion to her left cheek and forehead. The physician, licensed nurse and family were notified of the incident later that morning. The administrator further stated, a family member came in the facility on the afternoon of May 29, 2006, visited the identified resident, and there were no concerns voiced or complaints filed regarding the incident. Additionally, the administrator stated the identified resident's forehead was reddened and bruised the next day but she did not have a large "knot" or black eye.

On August 21, 2006 at 11:55 a.m., the identified resident's closed record was reviewed. The facility's "Incident Report" documented on May 29, 2006 at 3:30 a.m., the resident was in bed, became tangled in blankets, fell out of bed and sustained a carpet burn to the left side of her face and forehead. The physician and nurse were notified of the incident on May 29, 2006 at 10:00 a.m. The report further documented a family member was notified in person on May 29, 2006 at 1:15 p.m., regarding the incident.

The facility's "Progress Notes" dated May 29, 2006, (late entry) documented, "Staff was doing rounds and saw the identified resident wrapped up in blankets and falling onto the floor..." Staff noted the identified resident had abrasions to her left cheek, and that the resident's family was notified in person.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by notifying the resident's physician, licensed nurse, and the identified resident's family on May 29, 2006.

Allegation #2: An identified resident has had a sore on her knee for a year. The facility told the family it was because the resident would be on her knees praying frequently. Staff told the family they wouldn't let her stay on her knees for more than 15 minutes at a time.

Findings: Based on interview and record review it was determined the identified resident did periodically have reddened and chaffed knees from extended periods of time knelt in prayer.

On August 21, 2006 at 11:45 a.m., the administrator and the regional director were interviewed regarding the identified resident's sores on her knees. They indicated the resident did have recurring chaffed and sore areas on both knees. The resident would frequently kneel to pray causing reddened and chaffed areas that would last at most, one week. The resident's knees did required a bandaid on 1 or 2 different occasions. Staff were instructed to put a pillow beneath her knees, monitor the amount of time she was on her knees and redirect her if she was kneeling for more than 15 minutes.

On August 21, 2006 at 11:50 a.m., the identified resident's closed record was reviewed. The resident's Negotiated Service Agreement (NSA) dated June 9, 2006, instructed staff to ensure that a pillow is under the resident's knees when praying, watch her knees for redness and to redirect the resident after 15 minutes. After the resident was done praying staff were to immediately help her off the floor.

The "Progress Notes" dated June 12, 2006, documented the identified resident was found praying on the floor in her room by staff. When helping the resident up staff noticed she had an abrasion on both knees and her left elbow. Staff notified the physician, and family. Staff were instructed to check on her every 15 minutes.

On June 21, 2006, the "Progress Notes" documented, the identified resident's knees were looking good at that time. There was no further documented evidence that the resident was spending extended periods of time on her knees.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by educating all staff on interventions to prevent the identified resident from spending long periods of time praying on her knees.

Allegation #3: OnJuly 9, 2006, the identified resident's daughter found a puddle of urine in front of the toilet and there was no toilet paper in the bathroom.

Findings: Based on interview it was determined there was a puddle of urine in front of the identified resident's toilet. Additionally, toilet paper was being kept by staff to ensure the resident's roommate would not flush wads of toilet paper and plug up the toilet.

On August 21, 2006 at 11:55 a.m., the identified resident's NSA, dated 10/31/05, documented the resident required total assistance with toileting and staff were to perform peri-care after each episode of incontinence.

On August 21, 2006 at 11:15 a.m., during a tour of the facility residents' rooms and bathrooms were observed. The facility was found to be clean with no urine odors noted. Toilet paper was found in residents' bathrooms who were independent with toileting.

On August 21, 2006 at 11:45 a.m., the administrator, two staff members, and the regional director were interviewed regarding the identified resident's soiled bathroom. They stated, the resident had a roommate during that time and the roommate had soiled the bathroom floor. Staff felt it was priority to assist the roommate first, and then clean up the puddle of urine. Staff acknowledged toilet paper was not kept in the identified resident's bathroom due to her roommates habit of flushing too much toilet paper and clogging the toilet. Staff were instructed to bring toilet paper into the bathroom when they assisted the identified resident or her roommate with toileting.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by providing assistance and care to residents according to priority of needs.

Allegation #4: On May 9, 2006, the identified resident's son found the resident sitting with drool and blood running down her chin and onto her blouse and pants.

Findings: Based on interview and record review it was determined the facility protected the identified resident's clothing and tried to keep the resident clean and free of bloody drool after the resident had been to the dentist on May 8, 2006.

On August 21, 2006 at 11:15 a.m., during a tour of the facility the residents were observed about the facility. The residents appeared to be well groomed, and wearing clean clothing.

On August 21, 2006 at 11:45 a.m., the administrator, and the regional director were interviewed regarding the identified resident's soiled clothing. They indicated the resident had been to the dentist on May 8, 2006, for dental work. While the resident's mouth was still numb she bit the inside of her mouth and tongue causing her to drool and bleed. The administrator stated the resident's dentist was notified that the resident had bitten the inside of her mouth and tongue. She said the dentist advised them to offer the resident Tylenol for pain and change the gauze pads inside of the resident's mouth frequently, which staff did. Additionally, the administrator stated that staff frequently assisted the resident by keeping her face and clothing dry and free of blood and drool.

On August 21, 2006 at 11:55 a.m., the identified resident's closed record was reviewed. The resident's NSA, dated May 8, 2006, instructed staff to monitor the identified resident's mouth, keep her mouth and face clean, perform oral care 4 times a day and monitor for pain or discomfort.

Conclusion: Substantiated. However, the facility was not cited as they frequently assisted the resident to keep her face and clothing dry.

Allegation #5: The resident was not assisted with oral care.

Findings: Based on interview and record review it was determined the facility did assist the identified resident with oral care.

On August 21, 2006 at 11:30 a.m., two caregivers were interviewed. They stated it was care planned for every resident to receive oral care twice daily. If the resident refused during the offered times, the caregivers would try throughout the day to provide oral care. A caregiver stated when the identified resident had increased oral hygiene needs staff assisted the resident 4 times a day with oral care as directed by her NSA.

On August 21, 2006 at 11:55 a.m., the identified resident's closed record was reviewed. The identified resident's NSA dated May 8, 2006, instructed staff to assist the resident with oral care four times a day.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on August 21, 2006.

Allegation #6: On July 13, 2006, (the day the identified resident was moved from the facility) the daughter found her in bed at 10:45 a.m. with dried egg on her blouse and covered with feces.

Findings: Based on interview and record review it was determined the resident did have dried egg on her blouse and chocolate pudding on her face and hands, not feces.

On August 21, 2006 at 11:45 a.m., the administrator and the regional director were

interviewed regarding the identified resident's soiled clothing. The administrator acknowledged the identified resident had dried egg on her blouse. Staff were aware of the egg on her blouse but did not have a change of clothing as the family had taken the resident's clothes home the day before. Additionally, the administrator stated the resident had chocolate pudding in bed for her morning snack. She further stated, the family arrived during the snack and that staff offered to clean the resident prior to her leaving but the family refused.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately in offering to assisted the resident with personal cares prior to her moving from the facility.

Allegation #7: Staff is poorly trained to provide cares for the residents.

Findings: Based on observation, interview and record review it was determined the facility's staff members were properly trained to provide cares for residents.

On August 21, 2006 at 11:15 a.m., during a tour of the facility staff were observed caring for residents. The residents were being assisted with cares, and their needs were met.

On August 21, 2006 at 11:45 a.m. the administrator, and the regional director were interviewed regarding the facility's policy and procedure on training staff before providing resident care. The administrator stated all staff have a minimum of 32 hours of training, and new staff are not left alone during the one month of on the job training period. The administrator provided documentation of the required education prerequisite.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on August 21, 2006.

Allegation #8: A caregiver told the family that the identified resident had fallen out of bed and she could not get her up by herself so the resident was left on the floor all night.

Findings: Based on interview and record review there was no documented evidence that the identified resident fell out of bed another time, and was left on the floor all night.

On August 21, 2006 at 11:15 a.m., during a tour of the facility bed alarms were observed for residents who were at risk for falls. Call lights were observed attached to bedding, or placed near residents sitting in bedside chairs.

On August 21, 2006 at 11:45 a.m., the administrator, two staff members, and the regional director were interviewed regarding the identified resident's incidents and accidents. They stated the identified resident had one fall out of bed, which occurred on May 29, 2006. The administrator stated that the caregiver did assisted the resident back

to bed after the incident.

On August 21, 2006 at 12:15 p.m., the "Incident and Accident" reports were reviewed for the past 6 months. There was documented evidence that the resident had one fall out of bed. The incident report, dated May 29, 2006, did not document that staff had difficulty in assisting the resident back to bed.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on August 21, 2006.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Rebecca Whitis, RN for

RAE JEAN MCPHILLIPS
Team Leader
Health Facility Surveyor
Residential Community Care Program

RM/slc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program